Fax to: **Public Health – Seattle & King County** at **(206) 296-4803**

HEPATITIS C HEALTH CARE PROVIDER QUESTIONNAIRE

DEMOGRAPHICS

Patient name (Last, First): Birthdate: AGE: Last 4 SSN: _____

Gender: ☐ Female ☐ Female ☐Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Hispanic ☐Unknown

Race: ☐ Asian ☐ Amer Indian/Alaska Native ☐ Black ☐Other race, specify:
☐ White ☐ Native Hawaiian/Pacific Islander ☐ Unknown _____

Does the patient speak English? ☐ Yes ☐ No Primary language spoken:_____

CLINICAL

Date of initial HCV diagnosis (month/year):_____/_____

Reason for testing: *(check all)*

☐ Screening, asymptomatic with risk factors
☐ Screening, asymptomatic without risk factors
☐ Follow-up testing for previous marker of HCV
☐ Blood / organ donor screening
☐ Symptoms of hepatitis
☐ Prenatal screening
☐ Elevated LFTs
☐ Born during 1945–1965
☐ Unknown
☐ Other Specify: _____ _____

Is the patient pregnant? ☐ Yes (If yes, EDD:__/__/__) ☐ No ☐ Unknown

Does the patient have diabetes? ☐ Yes (If yes, date dx:__/__) ☐ No ☐ Unknown

Has the patient ever had a liver biopsy? ☐ Yes ☐ No ☐ Unknown

Does the patient have cirrhosis? ☐ Yes ☐ No ☐ Unknown

Has the patient ever been diagnosed with liver cancer? ☐ Yes ☐ No ☐ Unknown

Is the patient immune to hepatitis A (history of disease or vaccination)? ☐ Yes ☐ No ☐ Unknown

Is the patient immune to hepatitis B (history of disease or vaccination)? ☐ Yes ☐ No ☐ Unknown

LABORATORY

P N I NT *(P=positive/elevated, N=negative, I=indeterminate, NT=not tested)*

☐ ☐ ☐ ☐ HCV RNA qualitative

☐ ☐ ☐ ☐ HCV RNA quantitative Value:_____/ml ☐ I.U. ☐ RNA copies

If no HCV RNA confirmatory testing, primary reason: ☐ Patient lost to follow-up ☐ Patient declined
☐ Treatment not medically indicated ☐ Patient with limited life expectancy ☐ Other:_____

☐ ☐ ☐ ☐ HCV genotyping Result: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐Other:_____

☐ ☐ ☐ ☐ AST Actual value:_____ Date___/___/___

☐ ☐ ☐ ☐ ALT Actual value:_____ Date___/___/___

POTENTIAL EXPOSURES (Please complete as much as possible.)

Did the patient receive factor concentrates before 1987? ☐ Yes ☐ No ☐ Unknown

Did the patient receive blood products before 1992? ☐ Yes ☐ No ☐ Unknown

Did the patient ever receive an organ or tissue transplant? ☐ Yes (If yes, date:___/___) ☐ No ☐ Unknown

Was the patient ever on chronic hemodialysis? ☐ Yes ☐ No ☐ Unknown

Was the patient ever a contact of a person who had hepatitis? ☐ Yes ☐ No ☐ Unknown

Type of contact: ☐ Sexual ☐ Household ☐ Shared injection drug equipment ☐ Other:_____

Has the patient ever injected drugs not prescribed by a doctor? ☐ Yes ☐ No ☐ Unknown

Has the patient injected drugs not prescribed by a doctor in the past 3 months? ☐ Yes ☐ No ☐ Unknown

Did the patient likely acquire HCV through a medical or dental procedure? ☐ Yes ☐ No ☐ Unknown

Other possible risk factors for HCV? ☐ Yes ☐ No ☐ Unknown

Describe:

PATIENT MANAGEMENT

Does the patient have health insurance? ☐Yes ☐No ☐Unknown

Type: ☐Medicare ☐Medicaid ☐VA/military ☐Employer/private insurance ☐Individual/private insurance

Does the patient have a regular healthcare provider or clinic? ☐Yes ☐No ☐Unknown

Clinic / provider name:_____

Has the patient been seen or have an appointment for medical management of HCV? ☐Yes ☐No ☐Unknown

If yes, type of provider seen or will see: ☐ Primary care provider ☐ Specialist

If **no**, primary reason: ☐ Deceased ☐Incarcerated

☐ Patient declined, due to financial reasons (e.g., lack of insurance) ☐ Patient declined, perceived as unnecessary

☐ Appropriate provider not known ☐ Appropriate provider known, inaccessible to patient

☐ Other:_____

Has the patient ever been tested for hepatitis B virus? ☐Yes ☐No ☐Unknown

Has the patient ever been tested for HIV? ☐Yes ☐No ☐Unknown

Was the patient informed of the HCV test result? ☐Yes ☐No ☐Unknown

Was the patient educated on preventing HCV transmission? ☐Yes ☐No ☐Unknown

If not immune, was hepatitis A and hepatitis B virus vaccine recommended? ☐Yes ☐No ☐Unknown

Was the patient educated on avoiding liver toxins (e.g. ETOH)? ☐Yes ☐No ☐Unknown

If currently using injection drugs, was the patient educated on harm reduction and use of needle exchange programs? ☐Yes ☐No ☐Unknown

Were treatment options discussed with the patient? ☐Yes ☐No ☐Unknown

Was treatment recommended? ☐Yes ☐No ☐Unknown

If treatment was not recommended, why wasn't it recommended?_____

Has the patient received treatment? ☐Yes ☐No ☐Unknown

If **yes**, what is the status of treatment? ☐ Started ☐ Discontinued ☐ Completed

If **treatment was recommended but not started**, what was the primary reason for not starting treatment?

☐ Treatment prescribed, set to begin ☐ Appropriate provider not known ☐ Appropriate provider not accessible

☐ Patient financial barriers (e.g., no insurance) ☐ Perceived as unnecessary by patient

☐ Patient concerns about safety/adverse effects ☐ Other:_____

Person filling out form (Name, Title): _____